



Medical Assistance Administration



Kidney Center Services

Billing Instructions For Free-Standing Kidney Centers

[Chapter 388-540 WAC]

Current Procedural Terminology CPT

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About this publication

This publication supersedes all previous MAA Kidney Center Services Program Billing Instructions and Numbered Memorandum 03-48 MAA.

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Important Contacts

A provider may use MAA's toll-free lines for questions regarding its programs; however, MAA's response is based solely on the information provided to the [MAA] representative at the time of the call or inquiry, and in no way exempts a provider from following the rules and regulations that govern MAA's programs.
[WAC 388-502-0020(2)].

Where do I call for information to become a DSHS provider, to submit a change of address or ownership, or to ask questions about the status of a provider application?

Provider Enrollment Unit
(866) 545-0544

Where do I send my claims?

Division of Program Support
PO Box 9246
Olympia, WA 98507-9246

How do I obtain copies of billing instructions or numbered memoranda?

Go to MAA's web site at:
<http://maa.dshs.wa.gov>, Provider Publications/Fee Schedules link.

Who do I contact if I have questions regarding...

Policy, payments, denials, general questions regarding claims processing, Healthy Options, or to request billing instructions?

Provider Relations Section
(800) 562-6188

Prior Authorization?

Division of Medical Management
Medical Program Management Section
PO Box 45506
Olympia, WA 98504-5506
(360) 586-1471 Fax

Private insurance or third-party liability, other than Healthy Options?

Coordination of Benefits Section
(800) 562-6136

Electronic Billing?

Electronic Media Claims Help Desk
(360) 725-1267

Internet Billing?

<http://maa.dshs.wa.gov/ecs.htm>

Definitions

This section defines terms and acronyms used throughout these billing instructions.

Affiliate - A facility, hospital, unit, business, or person having an agreement with a kidney center to provide specified services to ESRD patients. [WAC 388-540-105]

Agreement - A written document executed between an ESRD facility and another facility in which the other facility agrees to assume responsibility for furnishing specified services to patients and for obtaining reimbursement for those services. [WAC 388-540-105]

Back-Up Dialysis - Dialysis given to patients under special circumstances, in a situation other than the patients' usual dialysis environment. Examples are:

- Dialysis of a home dialysis patient in a dialysis facility when patient's equipment fails;
 - In-hospital dialysis when the patient's illness requires more comprehensive care on an inpatient basis; and
 - Pre- and post-operative dialysis provided to transplant patients.
- [WAC 388-540-105]

Composite Rate - This refers to a payment method in which all standard equipment, supplies, and services are calculated into a blended rate. All in-facility dialysis treatments and all home dialysis treatments are billed under the composite rate system. [WAC 388-540-105]

Client – An individual who has been determined eligible to receive medical or health care services under any MAA program.

Code of Federal Regulations (CFR) – Rules adopted by the federal government.

Community Services Office(s) (CSO) - An office of the department which administers social and health services at the community level. [WAC 388-500-0005]

Continuous Ambulatory Peritoneal Dialysis (CAPD) - A type of dialysis where the patient's peritoneal membrane is used as the dialyzer. The patient dialyzes at home, using special supplies, but without the need for a machine (see Peritoneal Dialysis). [WAC 388-540-105]

Continuous Cycling Peritoneal Dialysis (CCPD) - A type of peritoneal dialysis where the patient dialyzes at home and utilizes an automated peritoneal cycler for delivering dialysis. [WAC 388-540-105]

Core Provider Agreement - The basic contract between the Medical Assistance Administration (MAA) and an entity providing services to eligible MAA clients. The core provider agreement outlines and defines terms of participation in Medical Assistance.

Department - The state Department of Social and Health Services (DSHS). [WAC 388-500-0005]

Dialysate - An electrolyte solution, containing elements such as potassium, sodium-chloride, etc., surrounding the membrane or fibers and allowing exchange of substances with the patient's blood in the dialyzer. [WAC 388-540-105]

Dialysis - A process by which dissolved substances are removed from a patient's body by diffusion from one fluid compartment to another across a semipermeable membrane.
[WAC 388-540-105]

Dialysis Session - The period of time beginning when the patient arrives at the facility and ending when the patient departs from the facility. In the case of home dialysis, the time period beginning when the patient prepares for dialysis and ending when the patient is disconnected from the machine. [WAC 388-540-105]

Dialyzer - Synthetic porous membrane or fibers, contained in a supporting structure, through which blood flows for the purpose of eliminating harmful substances, and replacing with useful ones.
[WAC 388-540-105]

End-Stage Renal Disease (ESRD) - The stage of renal impairment that is irreversible and permanent, and requires dialysis or kidney transplantation to ameliorate uremic symptoms and maintain life.
[WAC 388-540-105]

Epoetin Alpha (EPO) - An injectable drug that is a biologically engineered protein that stimulates the bone marrow to make new red blood cells. [WAC 388-540-105]

Explanation of Benefits (EOB) - A coded message on the Medical Assistance Remittance and Status Report that gives detailed information about the claim associated with that report.

Explanation of Medical Benefits (EOMB) – A federal report generated by Medicare for its providers that displays transaction information regarding Medicare claims processing and payments.

Fee-For-Service – A payment method MAA uses to reimburse providers for covered medical services provided to medical assistance clients, except those services provided under MAA's prepaid managed care programs.

Free-Standing Kidney Center - A limited care facility, not operated by a hospital, certified by the federal government to provide ESRD services.
[WAC 388-540-105]

Hemodialysis - A method of dialysis in which blood from a patient's body is circulated through an external device or machine and then returned to the patient's bloodstream. Hemodialysis is usually done in a kidney center or facility. It can be done at home with a trained helper.
[WAC 388-540-105]

Home Dialysis - Refers to any dialysis performed at home. [WAC 388-540-105]

Home Dialysis Helper - A person trained to assist the client in home dialysis.
[WAC 388-540-105]

In-Facility Dialysis - For the purpose of these billing instructions only, in-facility dialysis is dialysis of any type performed on the premises of the kidney center or other free-standing ESRD facility.
[WAC 388-540-105]

Intermittent Peritoneal Dialysis (IPD) - A type of peritoneal dialysis in which dialysis solution is infused into the peritoneal cavity, allowed to remain there for a period of time, and then drained out. IPD is usually done in a kidney center or facility. It can be done at home with a trained home dialysis helper.
[WAC 388-540-105]

Kidney Center - A facility as defined and certified by the federal government to:

- Provide ESRD services;
- Provide the services specified in this chapter; and
- Promote and encourage home dialysis for a client when medically indicated. [WAC 388-540-105]

Maintenance Dialysis - The usual periodic dialysis treatments given to a patient who has ESRD. [WAC 388-540-105]

Managed Care – A comprehensive system of coordinated medical and health care delivery including preventive, primary, specialty, and ancillary health services. [WAC 388-538-050]

Maximum Allowable - The maximum dollar amount MAA will reimburse a provider for a specific service, supply, or piece of equipment.

Medicaid - The state and federally funded Title IX program under which medical care is provided to persons eligible for the Categorically Needy (CNP) Program or Medically Needy (MNP) Program.

Medical Assistance Administration (MAA) - The administration within DSHS authorized by the secretary to administer the acute care portion of Title XIX Medicaid, Title XXI state-Children's Health Insurance Program (S-CHIP), Title XVI, and the state-funded medical care programs, with the exception of certain non-medical services for persons with chronic disabilities.

Medical Identification Card – The document MAA uses to identify a client's eligibility for a medical program. These cards were formerly known as Medical Assistance Identification (MAID) cards.

Medically Necessary - A term for describing [a] requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this section, "course of treatment" may include mere observation or, where appropriate, no treatment at all. [WAC 388-500-0005]

Medicare - The federal government health insurance program for certain aged or disabled clients under Titles II and XVIII of the Social Security Act. Medicare has two parts:

- "Part A" covers the Medicare inpatient hospital, post-hospital skilled nursing facility care, home health services, and hospice care.
- "Part B" is the supplementary medical insurance benefit (SMIB) covering the Medicare doctor's services, outpatient hospital care, outpatient physical therapy and speech pathology services, home health care, and other health services and supplies not covered under Part A of Medicare. [WAC 388-500-0005]

Patient Identification Code (PIC) - An alphanumeric code that is assigned to each MAA client and that consists of:

- First and middle initials (or a dash (-) must be entered if the middle initial is not indicated).
- Six-digit birthdate, consisting of *numerals only* (MMDDYY).
- First five letters of the last name (and spaces if the name is fewer than five letters).
- Alpha or numeric character (tiebreaker).

Peritoneal Dialysis - A procedure that introduces dialysate into the abdominal cavity to remove waste products through the peritoneum. Three forms of peritoneal dialysis are: Continuous Ambulatory Peritoneal Dialysis, Continuous Cycling Peritoneal Dialysis, and Intermittent Peritoneal Dialysis. [WAC 388-540-105]

Provider – Any person or organization that has a signed contract or Core Provider Agreement with DSHS to provide services to eligible clients.

Remittance and Status Report (RA) - A report produced by the Medicaid Management Information System (MMIS), MAA's claims processing system, that provides detailed information concerning submitted claims and other financial transactions.

Revised Code of Washington (RCW) - Washington State laws.

Self-Dialysis Unit - A unit in a free-standing kidney center where dialysis is performed by an ESRD client who has completed training in self-dialysis. [WAC 388-540-105]

Third Party – Any entity that is or may be liable to pay all or part of the medical cost of care of a medical program client.

Title XIX - The portion of the Federal Social Security Act that authorizes grants to states for medical assistance programs. Title XIX is also called Medicaid. [WAC 388-500-0005]

Usual & Customary Fee - The fee that the provider typically charged the general public for the product or service.

Washington Administrative Code (WAC) - Codified rules of the State of Washington.

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About the Program

What is the purpose of the Kidney Center Services program? [WAC 388-540-101]

The purpose of the Medical Assistance Administration (MAA) Kidney Center Services program is to assist low-income residents with the cost of treatment for end-stage renal disease (ESRD).

Provider Requirements [WAC 388-540-120]

To receive reimbursement from MAA for providing care to MAA clients, a kidney center must:

- Be a Medicare-certified ESRD facility;
- Have a signed Core Provider Agreement (CPA) with MAA and meet the requirements in WAC 388-502 Administrative Requirements-Providers (see <http://maa.dshs.wa.gov/provrel/cpa%20htm> for further information on the CPA);
- Provide only those services that are within the scope of their provider's license; and
- Provide, either directly or through an affiliate, all physical facilities, professional consultation, personal instructions, medical treatment, care, and all supplies necessary for carrying out a medically-sound ESRD treatment program, including all of the following:
 - ✓ Dialysis for clients with ESRD;
 - ✓ Kidney transplant treatment for ESRD clients when medically indicated;
 - ✓ Treatment for conditions directly related to ESRD;
 - ✓ Training and supervision of supporting personnel and clients for home dialysis, medical care, and treatment; and
 - ✓ Supplies and equipment for home dialysis.

Notifying Clients of Their Rights (Advance Directives)

[42 CFR, Subpart I]

All Medicare/Medicaid-certified hospitals, nursing facilities, home health agencies, personal care service agencies, hospices, and managed health care organizations are federally mandated to give **all adult clients** written information about their rights, under state law, to make their own health care decisions.

Clients have the right to:

- Accept or refuse medical treatment;
- Make decisions concerning their own medical care; and
- Formulate an advance directive, such as a living will or durable power of attorney, for their health care.

Client Eligibility

Who is eligible? [Refer to WAC 388-540-110 (1)]

To be eligible for MAA's Kidney Center Services program, a client must:

- Be diagnosed with ESRD or acute renal failure; and
- Present a current Medical Identification (ID) card with one of the following identifiers:

Medial Identification Card Identifier	Medical Program
CNP	Categorically Needy Program
CNP-CHIP	Categorically Needy Program - Children's Health Insurance Program
CNP Emergency Medical Only	Categorically Needy Program - Emergency Medical Only
MIP-EMER Hospital No-out-of-state care	Medically Indigent Program (Hospital-based services only)
GA-U No Out of State Care	General Assistance - Unemployable
LCP-MNP	Limited Casualty Program-Medically Needy Program



Note: Clients presenting a Medical ID card with the **MIP-EMER Hospital No-out-of-state care (Medically Indigent Program)** identifier are not eligible for the Kidney Center Services program.

* MAA reimburses providers for a client presenting a Medical ID card with a QMB-Medicare Only identifier for that client's deductible and coinsurance if Medicare has made payment (refer to page G.3).

Are clients enrolled in managed care eligible for Kidney Center Services? [Refer to WAC 388-540-110 (2)]

Yes! MAA managed care enrollees are eligible for Kidney Center services under their designated plan. Dialysis services must be arranged directly through the client's managed care plan. An identifier in the Health Maintenance Organization (HMO) column on the client's DSHS Medical ID card indicates that the client is enrolled in an MAA managed care plan. The client's plan covers hemodialysis, or other appropriate procedures to treat renal failure, including equipment needed in the course of treatment.

To prevent billing denials, please check the client's Medical ID card prior to scheduling services and at the time of service to make sure proper authorization or referral is obtained from the PCP and plan.

Primary Care Case Management (PCCM)

For the client who has chosen to obtain care with a PCCM, the identifier in the HMO column will be "PCCM." These clients must obtain, or be referred for, services via the PCCM. The PCCM is responsible for coordination of care just like the PCP would be in a plan setting. Please refer to the client's Medical ID card for the PCCM. (See the *Billing* section for further information.)



Note: To prevent billing denials, please check the client's Medical ID card prior to scheduling services and at the time of the service to make sure you obtain proper authorization or referral from the PCCM.

Coverage

What is covered? [Refer to WAC 388-540-130]

- MAA covers the following services subject to the restrictions and limitations in these billing instructions and applicable published WAC:
 - ✓ In-facility dialysis;
 - ✓ Home dialysis;
 - ✓ Training for self-dialysis;
 - ✓ Home dialysis helpers;
 - ✓ Dialysis supplies;
 - ✓ Diagnostic lab work;
 - ✓ Treatment for anemia; and
 - ✓ Intravenous drugs.



Note: Home dialysis helpers may assist a client living in the client's home or in a skilled nursing facility (when the skilled nursing facility is their home) with home dialysis.

- Covered services are subject to the limitations specified by MAA. Providers must obtain a limitation extension (LE) before providing services that exceed specified limits in quantity, frequency, or duration. See the Prior Authorization section for specifics on the LE process.

What is not covered? [Refer to WAC 388-540-140]

MAA does not cover the following in a kidney center:

- Blood and blood products (refer to WAC 388-540-190);
- Personal care items such as slippers, toothbrushes, etc.;
- Additional staff time or personnel costs. Staff time is paid through the composite rate. **Exception: Home dialysis helpers are the only personnel cost paid outside the composite rate (refer to WAC 388-540-160).**

MAA reviews all initial requests for noncovered services based on WAC 388-501-0165.

Services Covered by Other MAA Programs

[Refer to WAC 388-540-150 (5-6)]

The following services are covered under other MAA programs:

- Take Home Drugs – Take home drugs (outpatient prescription drugs not being administered in the provider's office) must be supplied and billed by a pharmacy subject to pharmacy pricing methodology outlined in MAA's Prescription Drug Program Billing Instructions.
- Medical Nutrition – Only pharmacies or other medical nutrition providers may supply supplemental food products. Bill for these services using MAA's Medical Nutrition Billing Instructions.

MAA's billing instructions may be viewed and downloaded at <http://maa.dshs.wa.gov>. Click on the Provider Publications/Fee Schedules link.

Prior Authorization

[Refer to WAC 388-531-0200]

Prior Authorization

Is prior authorization required for Kidney Center Services?

Yes. Prior authorization is required through a limitation extension.

Limitation Extensions

What is a Limitation Extension?

A limitation extension (LE) is MAA's authorization for the provider to furnish more units of service than are allowed in Washington Administrative Code (WAC) and MAA's billing instructions. The provider must provide justification that the additional units of service are medically necessary.

Limitation Extensions do not override the client's eligibility or program limitations. Not all categories of eligibility can receive all services. **For Example:** Kidney dialysis is not covered under the Family Planning Only Program.

How do I get LE authorization?

Obtain an LE by using the written/fax authorization process below.

Written/Fax Authorization

What is written/fax authorization?

Written or fax authorization is the paper authorization process providers must use when requesting an LE.

How do I obtain written/fax authorization?

Send or fax your request to the MAA Medical Request Coordinator (see Important Contacts) You must include the basic information contained in the sample fax/written request form on the next page. The sample form is provided for your convenience - its use is not mandatory, but you must include the information requested on this form when you request an LE.

(CPT codes and descriptions only are copyright 2002 American Medical Association.)

Fax/Written Request Basic Information

Provider Information

Name _____ Provider #: _____

Phone _____ Fax: _____

Client Information

Name _____ PIC# _____ - - -
i.e. (AB-122300-SMITH-A)

Service Request Information

Description of service being requested: _____

Revenue Code _____ Number of units requested _____

Medical Information

Diagnosis code _____ Diagnosis name _____

Place of service _____

What is the clinical justification for this request (for clients needing more than 14 dialysis sessions per month, please give the medical reason)?

Please send in any necessary additional documentation with your request to:

Fax: **360-586-1471** or mail to: Medical Request Coordinator
Division of Medical Management
PO Box 45506
Olympia, WA 98504-5506

Reimbursement

How does MAA reimburse for kidney center services?

[Refer to WAC 388-540-150]

The Medical Assistance Administration (MAA) recognizes a free-standing kidney center as an outpatient facility. MAA reimburses free-standing kidney centers for providing kidney center services to MAA clients using one of the following payment methods:

- **Composite rate payments** - A payment method in which all standard equipment, supplies, and services are calculated into a blended rate. All in-facility dialysis and all home dialysis treatments are billed under the composite rate system.
 - ✓ A single dialysis session and related services are reimbursed through a single composite rate payment (see “*What is included in the composite rate?*” for a detailed description on what is required and paid for in a composite rate payment).
 - ✓ The composite rate is listed in the Fee Schedule section.
- **Noncomposite rate payments** – ESRD services and items covered by MAA, but not included in the composite rate, are billed and paid separately. This methodology uses a maximum allowable fee schedule to reimburse providers (see “*What is not included in the composite rate?*” for more detail on noncomposite rate payments).

What is included in the composite rate? [WAC 388-540-160]

The following equipment, supplies, and services for in-facility and home dialysis are included in a composite rate:

- Medically necessary dialysis equipment;
- All dialysis services furnished by the facility's staff;
- Standard ESRD-related laboratory tests (see “Laboratory Services” on page E.3);
- Home dialysis support services including the delivery, installation, and maintenance of equipment;
- Purchase and delivery of all necessary dialysis supplies;
- Declotting of shunts and any supplies used to declot shunts;
- Oxygen and the administration of oxygen;
- Staff time used to administer blood and nonroutine parenteral items;
- Non-invasive vascular studies; and
- Training for self-dialysis and home dialysis helpers.

MAA issues a composite rate payment only when all of the above items and services are furnished or available at each dialysis session. If the facility fails to furnish or have available any of the above items, MAA does not pay for any part of the items and services that were furnished.

How many dialysis sessions are allowed?

[WAC 388-540-150 (1)(b) and (c)]

MAA reimburses providers for the following number of dialysis sessions:

- For revenue codes 821, 831, and 880, a maximum of 14 per client, per month.
- For revenue codes 841 and 851, a maximum of 31 per client, per month.



Note: Providers may request a limitation extension (LE) if more sessions than indicated above are medically necessary (see the Prior Authorization section).

What is not included in the composite rate? [WAC 388-540-170]

The following supplies and services are not included in the composite rate and may be billed separately, subject to the restrictions or limitations in these billing instructions and applicable published WAC:

- Drugs related to treatment, including but not limited to Epoetin Alpha (EPO) and diazepam. The drug must:
 - ✓ Be prescribed by a physician; and
 - ✓ Meet the rebate requirements described in WAC 388-530-1125; and
 - ✓ Meet the requirements of WAC 246-905-020 when provided for home use.
- Supplies used to administer drugs and blood.
- Blood processing fees charged by the blood bank (see "Blood Items and Services" on page F.5).
- Home dialysis helpers.



Note: Staff time for the administration of blood is included in the composite rate.

Laboratory Services [Refer to WAC 388-540-180]

- Standard ESRD lab tests are included in the composite rate when performed at recommended intervals.
- The following standard ESRD lab tests, performed by either the facility or an independent laboratory, may be reimbursed outside the composite rate when it is medically necessary to test more frequently. When submitting a claim for tests performed over and above recommended intervals:
 - ✓ Proof of medical necessity must be documented in the client's medical record when billing for more frequent testing. A diagnosis of ESRD is not sufficient.
 - ✓ The claim must include information on the nature of the illness or injury (diagnosis, complaint, or symptom) requiring the performance of the test(s) (an ICD-9CM diagnosis code may be shown in lieu of a narrative description).

Frequency of Testing Under ESRD Composite Rate	Standard ESRD Test
1. Per Treatment	All hematocrit, hemoglobin, and clotting tests
2. Weekly	Prothrombin time for patients on anti- coagulant therapy Serum Creatinine BUN
3. Monthly	Alkaline Phosphatase CBC LDH Serum Albumin Serum Bicarbonate Serum Calcium Serum Chloride Serum Phosphorous Serum Potassium SGOT Total Protein

Frequency of Testing Under ESRD Composite Rate	Standard ESRD Test																
	<p><u>CAPD Tests:</u></p> <table> <tr> <td>Albumin</td><td>LDH</td></tr> <tr> <td>BUN</td><td>Magnesium Alkaline</td></tr> <tr> <td>Calcium</td><td>Phosphatase</td></tr> <tr> <td>CO2</td><td>Phosphate</td></tr> <tr> <td>Creatinine</td><td>Potassium</td></tr> <tr> <td>Dialysate Protein</td><td>SGOT</td></tr> <tr> <td>HCT</td><td>Sodium</td></tr> <tr> <td>HGB</td><td>Total Protein</td></tr> </table>	Albumin	LDH	BUN	Magnesium Alkaline	Calcium	Phosphatase	CO2	Phosphate	Creatinine	Potassium	Dialysate Protein	SGOT	HCT	Sodium	HGB	Total Protein
Albumin	LDH																
BUN	Magnesium Alkaline																
Calcium	Phosphatase																
CO2	Phosphate																
Creatinine	Potassium																
Dialysate Protein	SGOT																
HCT	Sodium																
HGB	Total Protein																

- The following tests are **not** included in the composite rate and may be billed at the frequency shown without medical documentation. Tests performed more frequently require the appropriate medical diagnosis and medical documentation in the client's medical record (a diagnosis of ESRD alone is not sufficient).

Frequency of Testing for Separately Billable Tests	Test
<u>Hemodialysis & CCPD Patients</u>	
Once every three months:	Serum Aluminum Serum Ferritin
Once every twelve months:	Bone Survey (Either the roetgenographic method or the photon absorptiometric procedure for bone mineral analysis.)
<u>CAPD Patients</u>	
Once every three months:	Platelet count RBC WBC
Once every six months:	Residual renal function 24-hour urine volume

- All separately-billable ESRD laboratory services must be billed by, and reimbursed to, the laboratory that performs the test.

Blood Products and Services [Refer to WAC 388-540-190]

MAA reimburses free-standing kidney centers for:

- Blood processing and other fees assessed by non-profit blood centers that do not charge for the blood or blood products themselves; and
- Costs, up to MAA's maximum allowable fee, incurred by the center to administer its in-house blood procurement program.

MAA does not reimburse free-standing kidney centers for blood or blood products (refer to WAC 388-550-6500).

Staff time used to administer blood or blood products is included in the reimbursement for the composite rate (refer to WAC 388-540-150 and 388-540-160).

Epoetin Alpha (EPO) [Refer to WAC 388-540-200]

MAA reimburses the kidney center for EPO therapy when:

- Administered in the kidney center to a client:
 - ✓ With a hematocrit less than 33 percent or a hemoglobin less than 11 when therapy is initiated; or
 - ✓ Continuing EPO therapy with a hematocrit between 30 and 36 percent.
- Provided to a home dialysis client:
 - ✓ With a hematocrit less than 33 percent or a hemoglobin less than 11 when therapy is initiated; and
 - ✓ When permitted by Washington Board of Pharmacy Rules (refer to WAC 246-905-020 Home Dialysis Program--Legend Drugs).

For billing purposes, **100 units of EPO given to the client equals one (1) billing unit.** If a fraction of 100 units of EPO is given, round the billing unit as follows:

- If 49 units or less are given, round down to the next 100 units (i.e., bill 31,440 units of EPO as 314 billing units).
- If 50 units or more are given, round up to the next 100 units (i.e., bill 31,550 units of EPO as 316 billing units).

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Fee Schedule

The Kidney Center Services Fee Schedule is now located in the appendix. To view or download the Fee Schedule, click [Appendix](#).

The new 2006 additions and deletions are also available on the HRSA Fee Schedules web page. Visit our website at <http://maa.dshs.wa.gov>. To view a current fee schedule, click **Provider Publications/Fee Schedules**, then **Accept**, then **Fee Schedules**. The link to the fee schedule may not be available until July 1, 2006.

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Billing

What is the time limit for billing? [Refer to WAC 388-502-0150]

MAA has two timeliness standards for: 1) initial claims; and 2) resubmitted claims.

- **Initial Claims**

- ✓ MAA requires providers to obtain an ICN for an **initial claim** within 365 days from any of the following:
 - The date the provider furnishes the service to the eligible client;
 - The date a final fair hearing decision is entered that impacts the particular claim;
 - The date a court orders MAA to cover the services; or
 - The date DSHS certifies a client eligible under delayed¹ certification criteria.
- ✓ MAA may grant exceptions to the 365 day time limit for **initial claims** when billing delays are caused by either of the following:
 - DSHS certification of a client for a retroactive² period; or
 - The provider proves to MAA's satisfaction that there are extenuating circumstances.

¹ **Delayed Certification** - According to WAC 388-500-0005, delayed certification means department approval of a person's eligibility for a covered service made after the established application processing time limits. If, due to delayed certification, the client becomes eligible for a covered service that has already been provided, **the provider must not bill**, demand, collect, or accept payment from the client or anyone on the client's behalf for the service; and **must promptly refund** the total payment received from the client or anyone acting on the client's behalf and then bill MAA for the service.

Eligibility Established After Date of Service but Within the Same Month - If the client becomes eligible for a covered service that has already been provided because the client applied to the department for medical services later in the same month the service was provided (and is made eligible from the first day of the month), **the provider must not bill**, demand, collect, or accept payment from the client or anyone acting on the client's behalf for the service; and **must promptly refund** the total payment received from the client or anyone acting on the client's behalf and then bill MAA for the service.

² **Retroactive Certification** - According to WAC 388-500-0005, retroactive period means the three calendar months before the month of application (month in which client applied). If, due to retroactive certification, the client becomes eligible for a covered service that has already been provided, **the provider must not bill**, demand, collect, or accept payment from the client or anyone acting on the client's behalf for any unpaid charges for the service; **and may refund** any payment already received from the client or anyone acting on the client's behalf, and after refunding the payment, the provider may bill MAA for the service.

- **Resubmitted Claims**

Providers may **resubmit, modify, or adjust** any timely initial claim, except prescription drug claims, for a period of 36 months from the date of service. Prescription drug claims must be resubmitted, modified, or adjusted within 15 months from the date of service.



Note: MAA does not accept any claim for resubmission, modification, or adjustment after the time period listed above.

- The time periods do not apply to overpayments that the provider must refund to DSHS. After the allotted time periods, a provider may not refund overpayments to MAA by claim adjustment. The provider must refund overpayments to MAA by a negotiable financial instrument such as a bank check.
- The provider, or any agent of the provider, must not bill a client or a client's estate when:
 - ✓ The provider fails to meet these listed requirements; and
 - ✓ MAA does not pay the claim.

What fee should I bill MAA for eligible clients?

Bill MAA your usual and customary fee.

How do I bill for services provided to Primary Care Case Management (PCCM) clients?

When billing for services provided to PCCM clients:

- Enter the referring physician or PCCM name in form locator #83 on the UB-92 claim form; and
- Enter the seven-digit, MAA-assigned identification number of the PCCM who referred the client for the service(s). If the client is enrolled with a PCCM and the PCCM referral number is not in form locator #83 when you bill MAA, the claim will be denied.

How do I bill for clients who are eligible for both Medicare and Medicaid?

If a client is eligible for both Medicare and Medicaid, **you must first submit a claim to Medicare and accept assignment within Medicare's time limitations.** MAA may make an additional payment after Medicare reimburses you.

- If Medicare pays the claim, the provider must bill MAA within six months of the date Medicare processes the claim.
- If Medicare denies payment of the claim, MAA requires the provider to meet MAA's initial 365-day requirement for initial claims.

QMB (Qualified Medicare Beneficiaries) Program Limitations:

QMB with CNP or MNP (Qualified Medicare Beneficiaries with Categorically Needy Program or Medically Needy Program)

(Clients who have CNP or MNP identifiers on their medical ID card in addition to QMB)

- If Medicare **and** Medicaid cover the services, MAA will pay only the deductible and/or coinsurance up to Medicare's or Medicaid's allowed amount, whichever is less.
- If only Medicare **and not Medicaid** covers the service, MAA will pay only the deductible and/or coinsurance up to Medicare's allowed amount.
- If only Medicaid **and not Medicare** covers the service and the service is covered under the CN or MN program, MAA will reimburse for the service.

QMB-Medicare Only

The reimbursement criteria for this program are as follows:

- If Medicare **and** Medicaid cover the service, MAA will pay only the deductible and/or coinsurance up to Medicare's or Medicaid's allowed amount, whichever is less.
- If only Medicare **and not Medicaid** covers the service, MAA will pay only the deductible and/or coinsurance up to Medicare's allowed amount.
- If **Medicare does not** cover the service, MAA will not reimburse the service.

Third-Party Liability

You must bill the insurance carrier(s) indicated on the client's DSHS Medical ID Card. An insurance carrier's time limit for claim submissions may be different. It is your responsibility to meet MAA's and the insurance carrier's requirements relating to billing time limits, prior to any payment by MAA.

You must meet MAA's 365-day billing time limit even if you have not received notification of action from the insurance carrier. If your claim is denied due to any existing third-party liability, refer to the corresponding MAA Remittance and Status Report for insurance information appropriate for the date of service.

If you receive an insurance payment and the carrier pays you less than the maximum amount allowed by MAA, or if you have reason to believe that MAA may make an additional payment:

- Submit a completed claim form to MAA;
- Attach the insurance carrier's statement;
- If rebilling, also attach a copy of the MAA Remittance and Status Report showing the previous denial; or
- If you are rebilling electronically, list the claim number (ICN) of the previous denial in the comments field of the Electronic Media Claim (EMC).

Third-party carrier codes are available on the Internet at <http://maa.dshs.wa.gov>, or by calling the Coordination of Benefits Section at 1-800-562-6136.

What records must be kept? [Refer to WAC 388-502-0020]

Enrolled providers must:

- Keep legible, accurate, and complete charts and records to justify the services provided to each client, including, but not limited to:
 - ✓ Patient's name and date of birth;
 - ✓ Dates of service(s);
 - ✓ Name and title of person performing the service, if other than the billing practitioner;
 - ✓ Chief complaint or reason for each visit;
 - ✓ Pertinent medical history;
 - ✓ Pertinent findings on examination;
 - ✓ Medications (including NDC numbers), equipment, and/or supplies prescribed or provided;
 - ✓ Description of treatment (when applicable);
 - ✓ Recommendations for additional treatments, procedures, or consultations;
 - ✓ X-rays, tests, and results;
 - ✓ Plan of treatment and/or care, and outcome; and
 - ✓ Specific claims and payments received for services.
- Assure charts are authenticated by the person who gave the order, provided the care, or performed the observation, examination, assessment, treatment or other service to which the entry pertains.
- Make charts and records available to DSHS, its contractors, and the US Department of Health and Human Services, upon their request, for at least six years from the date of service or more if required by federal or state law or regulation.

**A provider may contact MAA with questions regarding MAA's programs. However, MAA's response is based solely on the information provided to MAA's representative at the time of inquiry, and in no way exempts a provider from following the laws and rules that govern MAA's programs.
(Refer to WAC 388-502-0020[2])**

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How to Complete the UB-92 Claim Form

General Instructions

Only form locators that pertain to billing MAA are addressed below.

When submitting more than one page of the UB-92, be sure to fully complete the first page. Only the detail lines are picked up from the second page. Please clearly indicate Page 1 of 2, Page 2 of 2, etc., in the *Remarks* section (*form locator 84*).

When billing electronically, indicate claim type "M" for Outpatient.



Note: Shaded fields are required fields only for UB-92 Medicare/Medicaid Crossover Claims." **Medicare/Medicaid Crossover Claims cannot be billed electronically.**

FORM LOCATOR NAME AND INSTRUCTIONS FOR COMPLETION:

- | | |
|--|--|
| <p>1. <u>Provider Name, Address & Telephone Number</u> - Enter the provider name, address, and telephone number as filed with the Medical Assistance Administration (MAA).</p> | <p>6. <u>Statement Covers Period</u> - Enter the beginning and ending dates of service for the period covered by this bill.</p> |
| <p>3. <u>Patient Control No.</u> - This is a 20-digit alphanumeric entry that you may use as your internal reference number. You create this number. Once you have submitted this account number to MAA, it will appear on the Remittance and Status Report under the column titled <i>Patient Account Number</i>.</p> | <p>12. <u>Patient Name</u> - Enter the client's last name, first name, and middle initial as shown on the client's medical identification card.</p> |
| <p>4. <u>Type of Bill</u> - Enter 722 or 723 (indicates free-standing ESRO facility).</p> | <p>13. <u>Patient's Address</u> - Enter the client's address.</p> |
| | <p>14. <u>Patient's Birthdate</u> - Enter the client's birth date.</p> |
| | <p>15. <u>Patient Sex</u> - Enter the client's sex.</p> |
| | <p>17. <u>Admit date</u> - Enter client's date of admittance.</p> |

18. **Admission Hour** - The hour during which the patient was admitted for outpatient care. Use the appropriate two-digit code listed in the following list:

<u>Code</u>	<u>Time: A.M.</u>	<u>Code</u>	<u>Time: P.M.</u>
00	12:00 - 12:59 (Midnight)	12	12:00 - 12:59 (Noon)
01	01:00 - 01:59	13	01:00 - 01:59
02	02:00 - 02:59	14	02:00 - 02:59
03	03:00 - 03:59	15	03:00 - 03:59
04	04:00 - 04:59	16	04:00 - 04:59
05	05:00 - 05:59	17	05:00 - 05:59
06	06:00 - 06:59	18	06:00 - 06:59
07	07:00 - 07:59	19	07:00 - 07:59
08	08:00 - 08:59	20	08:00 - 08:59
09	09:00 - 09:59	21	09:00 - 09:59
10	10:00 - 10:59	22	10:00 - 10:59
11	11:00 - 11:59	23	11:00 - 11:59

39-41. Value Codes and Amounts

- 39A: Deductible:** Enter the code *A1*, and the deductible as reported on your EOMB.
- 40A: Coinsurance:** Enter the code *A2*, and the coinsurance as reported on your EOMB.
- 41A: Medicare Payment:** Enter the payment by Medicare as reported on your EOMB.
- 41D: Medicare's Process Date:** Enter the date that Medicare processed the claim, as reported on your EOMB in numerals only (*MMDDYY*).

42. **Revenue Code** - Enter the appropriate revenue code(s) from the listing in this manual. Enter *001* in the last detail line 23 for total charges.

43. **Description - Revenue Code(s)** - Enter a narrative description of the related revenue or procedure codes included on this bill. Abbreviations may be used. Enter "**Total Charges**" on the last detail on line 23.

44. **HCPCS/Rates** - Enter the procedure code.

46. **Units of Service** - Enter the number of dialysis sessions, laboratory tests, and/or injectable drug units for which you are billing.

47. **Total Charges** - Enter charges pertaining to the related revenue code(s) or procedure code(s). **Total this column as the last detail on line 23.**

48. **Noncovered** - Enter any noncovered charges pertaining to detail revenue or procedure codes. (MAA will *categorically deny* these services.) **Total this column as the last detail on line 23.**

50. **Payer Identification: A/B/C** - Enter all health insurance benefits available.

50A: Enter *Medicaid*.

50B: Enter the name of additional insurance (e.g., Medicare, Aetna, etc.), if applicable.

50C: Enter the name of additional insurance, if applicable.

Medicare Crossover claims only

Medicare Crossover
claims only

- 51A. **Provider No.** – Enter the seven-digit Medical provider number beginning with a “3” that appears on your Remittance and Status Report.

51B: Enter your Medicare provider number.

54. **Prior Payments: A/B/C** - Enter the amount due or received from all insurances. **Do not include Spenddown or EMER here. See form locator 57.**

54A: Enter any prior payments from payor listed in form locator 50A.

54B: Enter any prior payments from payor listed in form locator 50B.

54C: Enter any prior payments from payor listed in form locator 50C.

55. **Estimated Amount Due: A/B/C** –

55A: Enter the estimated amount due from MAA minus any amounts listed in form locators 48, 54, and 57.

55B: Not required to be filled in.

55C: Not required to be filled in.

57. **Due from Patient (Patient Liability)** Enter the total patient liability amount which includes Spenddown and/or EMER.



Refer to the bottom of the client's *Approval for MI EMER/Spenddown Met* Letter issued by the local DSHS Community Service Office for the Spenddown and/or EMER amount.

58. **Insured's Name: A/B/C** – Enter the name of the individual in whose name the other insurance is carried.

60. **Cert-SSN-HIC-ID NO.** - Enter the Medicaid Patient (client) Identification Code (PIC) -an alphanumeric code assigned to each Medical Assistance client - exactly as shown on the client's medical identification card. This information consists of the client's:

- First and middle initials (or a dash [-] *must* be used if the middle initial is not available).
- Six-digit birth date, consisting of *numerals only* (MMDDYY).
- First five letters of the last name. If there are fewer than five letters in the last name, leave spaces for the remainder before adding the tie breaker.
- An alpha or numeric character (tiebreaker).

61. **Insurance Group Name** - If other insurance benefits are available, enter the name of the group or the plan through which insurance is provided to the insured.

62. **Insurance Group Number** - If other insurance benefits are available, enter any identification number that identifies the group through which the individual is covered.

63. **Treatment Authorization Code** - A number which designates the treatment covered by this bill has been authorized by the payer.

65. **Employer Name** - If other insurance benefits are available, enter the name of the employer that *might provide* or *does provide* health care coverage insurance for the individual.

67. **Principal Diagnosis Code** - Enter the ICD-9-CM diagnosis code describing the principal diagnosis.

- 68-75. **Other Diagnosis Codes** - Enter additional ICD-9-CM diagnosis codes indicating any other conditions.

82. **Attending Physician I.D.** - Enter the seven-digit provider identification number of the attending physician. Do not complete this box with a clinic billing number. For attending physicians not enrolled in the Medical Assistance program, enter the name of the attending physician in this form locator.

83. **Other Physician I.D.** - The name and/or number of the licensed physician other than the attending physician as defined by the payer organization.

84. **Remarks** - Enter any information applicable to this stay that is not already indicated on the claim form.

Kidney Center 900 Northwest Anytown WA 98000 (980) 555-9090		3		PATIENT CONTROL NO.		4 TYPE OF BILL	
5 FED. TAX NO.		6 STATEMENT COVERS PERIOD FROM		7 COV D		8 NCD	
9 C-D		10 L-R		11			
12 PATIENT ADDRESS		1000 Northwest		Anytown WA 98000			
14 BIRTHDATE		15 SEX		16 MS		17 DATE	
18 PR		19 TYPE		20 SRD		21 D HP	
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Kidney Center
900 Northwest
Anytown WA 98000
(360) 555-9090

2

3 PATIENT CONTROL NO.

4 TYPE
OF BILL

5 FED TAX NO.

6 STATEMENT COVERS PERIOD
FROM

7 COVD.

8 NCD.

9 CUD.

10 LRD.

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180024

010103 013103

12 PATIENT NAME

13 PATIENT ADDRESS

Jones, John A

1000 Northwest Anytown WA 98000

14 BIRTHDATE

15 SEX

16 MS

17 DAY

ADMISSION

18 HR

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Health & Recovery Services Administration (HRSA)
Kidney Centers Fee Schedule
Effective July 1, 2006

[Link To Legend For Code Status Indicator](#)

Code Status Indicator	Billing Code	Revenue Code	Comments	Max Allowable Fee
		0260	Requires Specific HCPCS Code	BR
R	A4750	0270		\$12.87
R	A4913	0270		\$24.59
		0303		BR
		0304		BR
	P9010	0390		*
	P9011	0390		BR
	P9012	0390		*
	P9016	0390		*
	P9017	0390		*
	P9019	0390		BR
	P9020	0390		BR
	P9021	0390		*
	P9022	0390		*
	P9023	0390		BR
	P9031	0390		BR
	P9032	0390		BR
	P9033	0390		BR
	P9034	0390		BR
	P9035	0390		BR
	P9036	0390		BR
	P9037	0390		BR
	P9038	0390		BR
	P9039	0390		BR
	P9040	0390		BR
	P9041	0390		*
	P9043	0390		*
	P9044	0390		BR
	P9045	0390		*
	P9046	0390		*
	P9047	0390		*
	P9048	0390		*
	P9050	0390		BR
	P9054	0390		BR
	P9055	0390		BR
	P9056	0390		BR
	P9057	0390		BR
	P9058	0390		BR
	P9059	0390		BR
	P9060	0390		BR
		0634		\$0.98
		0635		\$0.98
	90655	0636		*
	90656	0636		*
	90657	0636		*
	90658	0636		*

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Code Status Indicator	Billing Code	Revenue Code	Comments	Max Allowable Fee
	90660	0636		*
	90732	0636		*
	90747	0636		*
R	A4657	0636		\$0.25
	J0280	0636		*
	J0285	0636		*
	J0290	0636		*
	J0295	0636		*
	J0360	0636		*
	J0530	0636		*
	J0610	0636		*
	J0630	0636		*
	J0636	0636		*
	J0640	0636		*
	J0690	0636		*
	J0694	0636		*
	J0696	0636		*
	J0697	0636		*
	J0702	0636		*
	J0704	0636		*
	J0710	0636		*
	J0713	0636		*
	J0745	0636		*
	J0780	0636		*
	J0882	0636		*
	J0895	0636		*
	J0970	0636		*
	J1060	0636		*
	J1070	0636		*
	J1080	0636		*
	J1094	0636		*
	J1160	0636		*
	J1165	0636		*
	J1170	0636		*
	J1200	0636		*
	J1240	0636		*
	J1270	0636		*
	J1335	0636		*
	J1580	0636		*
	J1630	0636		*
	J1631	0636		*
	J1645	0636		*
	J1720	0636		*
	J1756	0636		*
	J1790	0636		*
	J1800	0636		*
	J1840	0636		*
	J1885	0636		*
	J1890	0636		*
	J1940	0636		*
	J1955	0636		*
	J1956	0636		*

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Code Status Indicator	Billing Code	Revenue Code	Comments	Max Allowable Fee
	J1990	0636		*
	J2001	0636		*
	J2060	0636		*
	J2150	0636		*
	J2175	0636		*
	J2270	0636		*
	J2275	0636		*
	J2320	0636		*
	J2321	0636		*
	J2322	0636		*
	J2501	0636		*
	J2510	0636		*
	J2540	0636		*
	J2550	0636		*
	J2560	0636		*
	J2690	0636		*
	J2700	0636		*
	J2720	0636		*
	J2765	0636		*
	J2800	0636		*
	J2916	0636		*
	J2920	0636		*
	J2930	0636		*
	J2995	0636		*
	J2997	0636		*
	J3000	0636		*
	J3010	0636		*
	J3070	0636		*
	J3120	0636		*
	J3130	0636		*
	J3230	0636		*
	J3250	0636		*
	J3260	0636		*
	J3280	0636		*
	J3301	0636		*
	J3360	0636		*
	J3364	0636		*
	J3365	0636		*
	J3370	0636		*
	J3410	0636		*
	J3420	0636		*
	J3430	0636		*
	J3490	0636		*
		0730		BR
R		0821	Per Session	\$201.41
		0825		BR
R		0831	Per Session	\$201.41
		0835		BR
R		0841	Per Session	\$86.32
		0845		BR
R		0851	Per Session	\$86.32
		0855		BR

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Code Status Indicator	Billing Code	Revenue Code	Comments	Max Allowable Fee
R		0880	Per Session	\$201.41
		0881		BR

Status Indictors

D = Discontinued Code

N = New Code

P = Policy Change

R = Rate Update

Not Covered in this program

ø Not covered by Medicaid

* = This fee may be found at:

<http://maa.dshs.wa.gov/RBRVS/Index.htm>

Click **on the most current injectable drugs fee Schedule**